MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

12463

Reg. Dist. No. 101

1. PLACE OF DEATH: COUNTY Charles — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Charlotte Hall — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md — COUNTY Chas.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Marbury Md
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Ohlie (Middle) (Last) Berry
4. DATE OF DEATH: (Month) 11 (Day) 5 (Year) 19 52

5. SEX M | 6. COLOR OR RACE C | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) S | 8. DATE OF BIRTH 8-10-14 | 9. AGE last birthday 38 yrs. | If under 1 year: Months / Days | If under 24 hrs: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer Laborer | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Joseph Berry | 14. MOTHER'S MAIDEN NAME Lizzie Berry

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT AND ADDRESS Goldie Travis (sister) 1319 Huntcourt S.W. DC

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
1955 Immediate cause (a)	5d
Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Unknown	11-5-52
(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) INJURY Home | (CITY OR TOWN) Marbury | (COUNTY) Chas | (STATE) Md.

TIME OF INJURY: (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

J. P. Adler MD — Port Tobacco Md — 11-6-52

23. BURIAL, ~~CREMATION~~ REMOVAL (Specify) | DATE THEREOF 11-11-52 | NAME OF CEMETERY OR CREMATORY Chicamuxen M E | LOCATION (City, town, or county) Chicamuxen (State) Md

DATE REC'D BY LOCAL REG. 11-10-52 | REGISTRAR'S SIGNATURE [illegible] | 24. FUNERAL DIRECTOR Hunter & Ryon Waldorf Md | ADDRESS

11-13-52 Mary Southerland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

COPY SENT TO LOCAL REGISTRAR ON ____ DATE ____

RECEIVED
JUL 13 1952
BUREAU V. S.

ITEMS 3,8, 23: film G151 2-1 9-53 L

12464

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 105

1. PLACE OF DEATH:
COUNTY Charles — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN White Plains Md
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Charles
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural White Plains Md
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) Carrie (Middle) BELLE (Last) Billingsley

4. DATE OF DEATH: (Month) Nov (Day) 29 (Year) 1952

5. SEX: F

6. COLOR OR RACE: W

7. ~~SINGLE, MARRIED~~, WIDOWED, ~~DIVORCED~~, (Specify):

8. DATE OF BIRTH: Dec 21 1872

9. AGE last birthday: 80 yrs. IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Self

11. BIRTHPLACE (State or foreign country): Prince Georges Md

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Richard Linsley

14. MOTHER'S MAIDEN NAME: Georgiana ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No

16. SOCIAL SECURITY NO.: No

17. INFORMANT & ADDRESS: Roger Billingsley Son

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

422.1

Immediate cause (a) Respiratory Sepsis. — Interval between onset and death: 8 hours

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

DUE TO (b) Cerebral vascular accident — 8 hours

DUE TO (c) Senile Arteriosclerosis and myocardial degeneration — 3 years.

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) —

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M. —

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from June, 1951, to 29 Nov., 1952, that I last saw the deceased alive on 29 Nov., 1952, and that death occurred at 7:10 p.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED

J Woody. MD — La Plata. Md. — 29 Nov 52.

23. BURIAL, ~~CREMATION~~ REMOVAL (Specify): — DATE THEREOF: Dec 2-52 — NAME OF CEMETERY OR CREMATORY: Old Bapt McKendree — LOCATION (City, town, or county) (State): Cobb Island Md

DATE REC'D BY LOCAL REG. 12/1/52 — REGISTRAR'S SIGNATURE: M. L. Thomas — 24. FUNERAL DIRECTOR AND ADDRESS: Arnold H Gore Waldorf Md

VS. A15 8-51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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DEC 3 19[illegible]
BUREAU V. S.

COPY SENT TO LOCAL REGISTRAR No. ____ DATE ____

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

12465

CERTIFICATE OF DEATH

Reg. Dist. No. 100

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH: COUNTY CHARLES — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN LA PLATA | LENGTH OF STAY (in this place) 15 Days
HOSPITAL OR INSTITUTION OR STREET ADDRESS PHYSICIANS' MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MAINE — COUNTY KNOX
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ROCKLAND
STREET ADDRESS (If rural, give location) 100 PARK ST.

3. NAME OF DECEASED (Type or Print): (First) ETHEL (Middle) RUTH (Last) BORGERSON
4. DATE OF DEATH: (Month) NOVEMBER (Day) 10 (Year) 1952

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
FEMALE	WHITE - U.S.	MARRIED	JANUARY 1, 1892	60 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE	HOME	SOUTH THOMASTON, MAINE	U.S.

13. FATHER'S NAME: FRED W. PIERCE
14. MOTHER'S MAIDEN NAME: HATTIE HEARD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
NO	NONE.	MR. CARL BORGERSON; 100 PARK ST. ROCKLAND, MAINE.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) CEREBRAL HEMORRHAGE, LEFT	15 days
Antecedent cause(s) — Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) CEREBRAL HEMORRHAGE, RIGHT (RESIDUAL LEFT HEMIPLEGIA)	2 YEARS
	(c) ESSENTIAL HYPERTENSION	10 YEARS

331.1

II. OTHER SIGNIFICANT CONDITIONS. Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from OCTOBER 26, 1952, to NOVEMBER 10, 1952, that I last saw the deceased alive on NOVEMBER 10, 1952, and that death occurred at 7 07 P.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
John H. Griffin	M.D.	HUGHESVILLE, MD.	11/12/52

23. BURIAL, ~~CREMATION~~ REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
	11-14-52	Ash Point	Ash Point Maine

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
11-11-52	John L. Mayo Jr.	Hunt & Ryon Waldoy Md	
11-12-52	John H. Casey		

VS-A15

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BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

12466

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 100

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Charles — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bryantown
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Pa. COUNTY Del.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Philadelphia
STREET ADDRESS (If rural, give location) 2721 - Leo St.

3. NAME OF DECEASED (Type or Print): (First) RAYMON (Middle) J (Last) BROCKWAY
4. DATE OF DEATH: (Month) 11 (Day) 14 (Year) 19 52

5. SEX M | 6. COLOR OR RACE W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) M | 8. DATE OF BIRTH 7-22-10 | 9. AGE last birthday 42 yrs. | If under 1 year: Months, Days | If under 24 hrs: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter
10b. KIND OF BUSINESS OR INDUSTRY Industrial
11. BIRTHPLACE (State or foreign country) Lake Placid N.Y.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME John Brockway
14. MOTHER'S MAIDEN NAME Jean Hammond Phil. Pa.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) No
16. SOCIAL SECURITY NO. 164-16-4862
17. INFORMANT AND ADDRESS Anna Brockway 2721 - Leo St.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Fractured Cervical Vertebrae — Interval Between Onset and Death: 11-14-52

816.4

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b)
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Highway | (CITY OR TOWN) Bryantown | (COUNTY) Chas | (STATE) Md.

TIME OF INJURY (Month) 11 (Day) 14 (Year) 52 (Hour) Pm. | INJURY OCCURRED While at work ☐ Not while at work ☒ | HOW DID INJURY OCCUR? Driving car which ran into back of school bus

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) C. H. Adelen M.D. | ADDRESS La Plata Md | DATE SIGNED 11-15-52

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE THEREOF 11-19-52 | NAME OF CEMETERY OR CREMATORY Holy Cross | LOCATION (City, town, or county) Gordon (State) Pa.

DATE REC'D BY LOCAL REG. 11/15/52 | REGISTRAR'S SIGNATURE Julia H. Cadey | 24. FUNERAL DIRECTOR, ADDRESS Donald J. Phillips, 568-N. 23 st. Phil. Pa.

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NOV 17 1903
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

12467

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 106

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Charles — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Indian Head
LENGTH OF STAY (in this place): 4 mths
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Potomac River off Dry Dock U.S Naval Powder Factory

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Pennsylvania — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Philadelphia
STREET ADDRESS (If rural, give location): 1827 Stiles Street.

3. NAME OF DECEASED (Type or Print): (First) Maurice (Middle) Thomas (Last) Cleary

4. DATE OF DEATH: (Month) November (Day) 14 (Year) 1952

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Feb 18 1924

9. AGE last birthday: 28 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Gunner

10b. KIND OF BUSINESS OR INDUSTRY: U-S Navy

11. BIRTHPLACE (State or foreign country): Philadelphia Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: deceased (Not Known)

14. MOTHER'S MAIDEN NAME: Henrietta Fogel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes — (If yes, give war or dates of service): 1941-1952

16. SOCIAL SECURITY NO.:

17. INFORMANT AND ADDRESS: Navy Records. U.S Naval Powder Factory Indian Head Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Drowning accidental — Immediate

Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

E 979.8

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: None

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: Potomac River — (CITY OR TOWN): Indian Head — (COUNTY): Charles — (STATE): Md.

TIME OF INJURY (Month) (Day) (Year) (Hour): Nov. 14, 1952 9:30 A.m. — INJURY OCCURRED While at work ☒ Not while at work ☐ — HOW DID INJURY OCCUR? While practice diving during training

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE: Frank G. Swanson (Degree or title) — ADDRESS: Indian Head Md. — DATE SIGNED: 11-14-52

23. BURIAL, CREMATION, REMOVAL (Specify): Transportation — DATE THEREOF: — NAME OF CEMETERY OR CREMATORY: U.S.N.H. Bethesda — LOCATION (City, town, or county) (State): Bethesda, Md

DATE REC'D BY LOCAL REG.: 11/13/52 — REGISTRAR'S SIGNATURE: Odey Price

24. FUNERAL DIRECTOR — ADDRESS: Robert Pumphrey Bethesda, Md.

VS. A15A

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Item 18 Film G149 12-12-52 ams

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 1 27

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. 415A

1. PLACE OF DEATH: COUNTY Charles — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN La Plata — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Physicians Mem. Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. — COUNTY Charles
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Issue
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) CORNELIUS (Middle) (illegible) (Last) GILBERT
4. DATE OF DEATH: (Month) 11 (Day) 25 (Year) 52

5. SEX M. | 6. COLOR OR RACE C | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) M | 8. DATE OF BIRTH 1904 | 9. AGE last birthday 48 yrs. | If under 1 year: Months / Days | If under 24 hrs: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer — 10b. KIND OF BUSINESS OR INDUSTRY Work. retired
11. BIRTHPLACE (State or foreign country) Md. — 12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Luke Gilbert — 14. MOTHER'S MAIDEN NAME Lina Biden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W.W. I — 16. SOCIAL SECURITY NO. — 17. INFORMANT AND ADDRESS Bessie Cornish, Issue, Md.

18. MEDICAL CERTIFICATION

19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

812.4 **Immediate cause** (a) Cerebral Hemorrhage — 11 days

Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (b) caused by the Automobile accident.

(c)

20. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

21a. DATE OF OPERATION — 21b. MAJOR FINDINGS OF OPERATION — 22. AUTOPSY? Yes ☐ No ☐

23. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. — PLACE (Home, farm, factory, street, office bldg., etc.) Hwy — (CITY OR TOWN) Issue — (COUNTY) Chas. — (STATE) Md.

TIME OF INJURY (Month) 12 (Day) 25 (Year) 52 (Hour) 7 p.m. — INJURY OCCURRED While at work ☐ Not while at work ☐ — HOW DID INJURY OCCUR? Hit by auto on Highway

24. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐*

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED

25. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 12-1-52 — NAME OF CEMETERY OR CREMATORY Hickory Grove — LOCATION (City, town, or county) (State) Issue, Md.

DATE REC'D BY LOCAL REG. 11/29/52 — REGISTRAR'S SIGNATURE Julia H. Farley — 26. FUNERAL DIRECTOR — ADDRESS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 100

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
COUNTY Charles — MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) Newburg
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Charles
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Newburg
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (First) Theodore (Middle) (Last) Fenwick

4. DATE OF DEATH: (Month) 11 (Day) 21 (Year) 1952

5. SEX: M.

6. COLOR OR RACE: C.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): M.

8. DATE OF BIRTH: Nov. 14, 1916

9. AGE last birthday: 36 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tenant Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Leo Fenwick

14. MOTHER'S MAIDEN NAME: Mamie Knott

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No
(If Yes, give war or dates of service) —

16. SOCIAL SECURITY NO.: —

17. INFORMANT & ADDRESS: Marguerite Fenwick, Newburg, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

INTERVAL BETWEEN ONSET AND DEATH

022X
Immediate cause (a) Ruptured Aortic Aneurysm
DUE TO
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last
(b) Tertiary Lues
DUE TO
(c) Hypertension

II. OTHER SIGNIFICANT CONDITIONS:
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/17, 1952 to 11/21, 1952, that I last saw the deceased alive on 11/17, 1952, and that death occurred at 10:30 P.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED
Richard T. Daly, M.D. 11/24/52

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF 11-24-52
NAME OF CEMETERY OR CREMATORY St. Marys
LOCATION (City, town, or county) (State) Newport, Md.

DATE REC'D BY LOCAL REG. 11/24/52
REGISTRAR'S SIGNATURE Julia H. Casey
24. FUNERAL DIRECTOR ADDRESS Hunt & Byrn, Waldorf, Md.

VS. A.M. 8-51

RECEIVED
NOV 26 1952
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 10

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Charles, MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Port Tobacco
LENGTH OF STAY (In this place) 7 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Charles
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Du Bois
STREET ADDRESS (If rural, give location) Charlotte Hall, R.D.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
WILLIAM	ELLIS	GROSS	11	7	19 52

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	If under 1 year: Months	Days	If under 24 hrs: Hours	Min.
M	C	W	11-5-52	✓		1		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
WILLIAM SYLVESTER GROSS	SARAH ELIZABETH DORSEY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
		Father, Wm. Gross

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Prematurity	11 hrs
776X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)	11 hrs
(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
—	—	

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
		Du Bois	Chas	Md.

TIME (Month) (Day) (Year) (Hour) OF INJURY m.	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection X, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
[illegible]	M.D.	Charlotte Hall, Md.	11-7-52

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	11/8/52	St. Mary's	Newport, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
11/8/52	Julia H. Posey	Wm. Gross, Father	Charlotte Hall, Md.

40 X 2 a 33462

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

2471

Reg. Dist. No. 1[illegible]

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS AHA

1. PLACE OF DEATH: COUNTY [illegible] MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN [illegible]; LENGTH OF STAY (In this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS [illegible]

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE [illegible] COUNTY [illegible]; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Newburg; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) FREDERICK (Middle) JOHN (Last) HARVEY

4. DATE OF DEATH: (Month) 11 (Day) [illegible] (Year) 19[illegible]

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): M

8. DATE OF BIRTH: 7-1-[illegible]

9. AGE last birthday: [illegible] yrs. If under 1 year: Months / Days; If under 24 hrs: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer - Dec

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): [illegible]

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CLEVELAND HARVEY

14. MOTHER'S MAIDEN NAME: ANNIE M. GOLDSMITH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY No.

17. INFORMANT AND ADDRESS: Robert C. Harvey, Newburg, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

816.4 **Immediate cause** (a) Compound - comminuted fracture

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) of skull - 11 26 xx

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ( ) OR CONTRIBUTING ( ) CAUSE OF DEATH. PLACE (Home, farm, factory, street, office bldg., etc.) [illegible] (CITY OR TOWN) [illegible] (COUNTY) Chas (STATE) Md.

TIME OF INJURY (Month) 11 (Day) 26 (Year) [illegible] (Hour) 5:-10 PM | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR? Auto collision

22. *I certify that I took charge of the remains described above, held an Autopsy ( ), Inspection ( ), Inquiry ( ) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ( ), accident (X), suicide ( ), homicide ( ), undetermined ( ).*

SIGNATURE [illegible] (Degree or title) ADDRESS [illegible] DATE SIGNED [illegible]

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF 11-[illegible]-xx | NAME OF CEMETERY OR CREMATORY [illegible] | LOCATION (City, town, or county) Leonardtown (State) Md.

DATE REC'D BY LOCAL REG. 11-[illegible]-xx | REGISTRAR'S SIGNATURE [illegible]

24. FUNERAL DIRECTOR [illegible] ADDRESS [illegible]

Item 20 Film 3150 2-4-53 ams

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 12 2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Charles
City or town: Indian Head
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life time
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Charles
City or town: Indian Head
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME Lucy C Hawkins

3. (b) Social Security Number

4. Sex: F
5. Color or race: Col
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Charles W. Queen
6.(c) If alive, give age: 44 years
7. Birth date of deceased (mo., day, yr.): Nov 5, 1919
8. AGE: Years 33 Months 1 Days If less than one day hrs. min.
9. Birthplace: Indian Head, Md. (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business:

MOTHER FATHER

12. Name: John Hawkins
13. Birthplace: Charles Co. Md
14. Maiden name: Eliza Milburn
15. Birthplace: Charles Co. Md
16. Informant: Charles W. Queen
Address: Indian Head
17. Burial. Date thereof 11/5/52 (Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: St. Charles.
Location: Indian Head.
18. Funeral director: Stanley Penn
Address: Pisgah Md
19. (Date rec'd by registrar) 19 52 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 5 1952 at 8:20 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 5 1952 to 19
and that I last saw h.. alive on Nov 5 1952

Immediate cause of death	DURATION
As Cardiac Failure	
Due to: Possibly thematic	
Due to:	
Other conditions: 416X (Include pregnancy within 3 months of death)	

Major findings of operations: Date of op
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: George O Bidwell M.D. M. D. or other
Address: Mardela Md Date signed: Nov 6 52

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 161

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Charles — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Risen — LENGTH OF STAY (In this place) 2 wks
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Charles
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Risen.
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Nancy (Middle) Ann (Last) Linkins
4. DATE OF DEATH: (Month) Nov. (Day) 24 (Year) 1952
5. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single
8. DATE OF BIRTH: 9-8-52
9. AGE last birthday: yrs. — If under 1 year: Months 2 Days 16 — If under 24 hrs.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): infant
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): New York City, NY
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Melvin J. Linkins
14. MOTHER'S MAIDEN NAME: Flossie V. Price
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: — —
17. INFORMANT AND ADDRESS: Mrs. Melvin J. Linkins Risen, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

765.5 Immediate cause (a) Cerebral Hemorrhage (Intracranial) — Immed.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Prematurity (Baby was 2 months — Premature

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at work ☐ Not while at work ☐ — HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE — (Degree or title) — ADDRESS — DATE SIGNED

Frank L. Susan Li. S. — Indian Head, Md — 11-24-52

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF 11-24-52 — NAME OF CEMETERY OR CREMATORY Alexander M. E. — LOCATION (City, town, or county) Chicamuxen — (State) Md.

DATE REC'D BY LOCAL REG. 11/24/52 — REGISTRAR'S SIGNATURE Mervin Smallwood — 24. FUNERAL DIRECTOR Nathan Linkins — ADDRESS Risen, Md.

VS. A15A

RECEIVED
NOV 26 1952
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 100

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY: Charles — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: La Plata
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Physicians Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Md. COUNTY: Charles
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cobb Island
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED: (Type or Print) (First) DEBORAH (Middle) Lee (Last) LOMAX

4. DATE OF DEATH: (Month) Nov. (Day) 2 (Year) 1952

5. SEX: Female

6. COLOR OR RACE: W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): S.

8. DATE OF BIRTH: 11-1-52

9. AGE last birthday: yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours 7 / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): La Plata, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Eldridge Lomax

14. MOTHER'S MAIDEN NAME: Nellie Elizabeth Bailey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): no (If Yes, give war or dates of service) no

16. SOCIAL SECURITY No.: none

17. INFORMANT & ADDRESS: Mr. James E. Lomax, Cobb Island, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

7745

Immediate cause (a) Respiratory failure — INTERVAL BETWEEN ONSET AND DEATH: 20 min

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) Prematurity, six months development

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): —

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1 Nov., 1952, to 2 Nov., 1952, that I last saw the deceased alive on 2 Nov., 1952, and that death occurred at 12:20 A.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED

M Elwood MD La Plata. Md. 2 Nov 52

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF 11/3/52 — NAME OF CEMETERY OR CREMATORY Holy Sheet — LOCATION (City, town, or county) (State) Issue, Md.

DATE REC'D BY LOCAL REG. 11/3/52 — REGISTRAR'S SIGNATURE Julia H. Casey — 24. FUNERAL DIRECTOR Hurst & Ryon, Waldorf, Md — ADDRESS

20X2203261

VS. A15 8-51

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 100

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Charles MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rison (rural) LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Charles
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rison
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Milton (Middle) C (Last) Milstead

4. DATE OF DEATH: (Month) 11 (Day) 6 (Year) 19 52

5. SEX M | 6. COLOR OR RACE C | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) M | 8. DATE OF BIRTH 4-22-01 | 9. AGE last birthday 51 yrs. | If under 1 year: Months, Days | If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber | 10b. KIND OF BUSINESS OR INDUSTRY Barber | 11. BIRTHPLACE (State or foreign country) Maryland | 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John Milstead | 14. MOTHER'S MAIDEN NAME Mrs. Hallen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT AND ADDRESS Irving Milstead, Rison, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

491X Immediate cause (a) Pneumonia — 11 5 d.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b)
(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☑ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy X, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE C. Helen (Degree or title M.D.) ADDRESS Rison Md. DATE SIGNED 11 7 52

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE THEREOF 11/10/52 | NAME OF CEMETERY OR CREMATORY Chicamuxen | LOCATION (City, town, or county) (State) Rison Md

DATE REC'D BY LOCAL REG. 11/8/52 | REGISTRAR'S SIGNATURE Julia H. Casey | 24. FUNERAL DIRECTOR Stanley Penny, Pisgah, Md. ADDRESS

VS. A15A

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 1 20

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct answer is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Charles — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Welcome | LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Charles
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Welcome
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) RAYMOND (Middle) W (Last) HAMEL PRESTON
4. DATE OF DEATH: (Month) 11 (Day) 19 (Year) 1952

5. SEX M | 6. COLOR OR RACE W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) M | 8. DATE OF BIRTH 6-17-52 | 9. AGE last birthday yrs. | If under 1 year: Months 5 | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Welcome, Md
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME THOMAS PRESTON
14. MOTHER'S MAIDEN NAME ANNA CRAIG

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS Thomas Preston, Welcome, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Lobar Pneumonia — 11 days

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) Cerebral Hemorrhage — 11 16 days
(c) Hypertension (Death not Verified)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ___, Inspection X Inquiry ___ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
(C. [illegible] M.D.) Welcome, Md. 11-19-52

23. BURIAL, CREMATION, REMOVAL. (Specify) Burial | DATE THEREOF 11/20/52 | NAME OF CEMETERY OR CREMATORY Zion Baptist | LOCATION (City, town, or county) (State) Hilltop, Md.

DATE REC'D BY LOCAL REG. 11/19/52 | REGISTRAR'S SIGNATURE [illegible] | 24. FUNERAL DIRECTOR [illegible] ADDRESS Preston, Welcome, Md.

406231936 8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 105

1. PLACE OF DEATH:

County Charles

City or town Waldorf Md (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md County Charles

City or town Waldorf Md (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME William Narvill Richards

3. (b) Social Security Number 218-12-9110

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced
M	W	Married

6.(b) Name of husband or wife Bessie

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb 4 - 1894

8. AGE: Years 58 Months Days If less than one day ..... hrs. ..... min.

9. Birthplace Charles Co Md (Town, county, and state)

10. Usual occupation Painter

11. Industry or business Sup

MOTHER FATHER

12. Name John W. Richards

13. Birthplace

14. Maiden name Laura Hurbert

15. Birthplace

16. Informant Bessie Richards Wife

Address Waldorf md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-2-52 (month) (day) (year)

Cemetery or crematory Arlington Nat

Location Arlington Va

18. Funeral director Hunt & Ryon

Address Waldorf md

19. 11-29 19 52 M. L. Mervell Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 | 29 19 52 at 4:30 A M

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from June 19 42 to 11-27 19 52 and that I last saw h. alive on 11-27 19 52

Immediate cause of death	DURATION
(a) Cerebral Hemiplegia	4 years
Due to (b) Cardio-Vas Renal Disease	
Due to (c) Arteria Sclerosis	
Other conditions Hypertension	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [signature] M.D. M. D. or other

Address Waldorf Md Date signed 11-27-52

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 [illegible]478

CERTIFICATE OF DEATH

Reg. Dist. No. 100

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Charles — MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) Newburg
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Charles
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Newburg
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) Joseph (Middle) (Last) Stine

4. DATE OF DEATH: (Month) Nov. (Day) 21 (Year) 19 52

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): M.

8. DATE OF BIRTH: 1-17-83

9. AGE last birthday: 69 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Fisherman

10b. KIND OF BUSINESS OR INDUSTRY: Self

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U S

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No

(If Yes, give war or dates of service) —

16. SOCIAL SECURITY No.: —

17. INFORMANT & ADDRESS: Charles Stine

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

331X

Immediate cause (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 11-21-52

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) Hypertension — 1946

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M. INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 19..., to 11-21-52, 19..., that I last saw the deceased alive on 11-19-52, 19..., and that death occurred at 5 p.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) M.D. ADDRESS La Plata Md. DATE SIGNED 11-24-52

23. BURIAL, CREMATION, REMOVAL. (Specify): Burial — DATE THEREOF 11/24/52 — NAME OF CEMETERY OR CREMATORY Holy Ghost — LOCATION (City, town, or county) (State) Issue Md.

DATE REC'D BY LOCAL REG. 11/24/52 — REGISTRAR'S SIGNATURE Julia H. Casey

24. FUNERAL DIRECTOR — ADDRESS Hewitt & Ryon Waldorf Md.

VS. A16 8-51

RECEIVED
NOV 26 1952
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10 V

1. PLACE OF DEATH:

County Charles Md

City or town Newport
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? since birth

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infant, give residence of mother)

State Maryland County Charles

City or town Newport
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war rural

3.(a) FULL NAME Richard Bartholomew Thomas

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col	single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 19-1952

8. AGE: Years / Months 1 / Days 9 / If less than one day hrs. min.

9. Birthplace Newport Charles Co Md
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Joseph Andrew Thomas

13. Birthplace St Marys Co Md

MOTHER 14. Maiden name Mary Elizabeth Campbell

15. Birthplace Charles Co Md

16. Informant Joseph A. Thomas

Address Newport Charles Co Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-28-52 (month) (day) (year)

Cemetery or crematory St. Mary's Cemetery

Location Newport Maryland

18. Funeral director Joseph A. Thomas

Address Newport, Md.

19. 11/28/52 (Date rec'd by registrar) 19 Julia H. Posey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 28 1952 at 4:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 24 1952 to Nov 28 1952 and that I last saw h alive on Nov 27 1952

Immediate cause of death	DURATION
Enteric Fever	
Due to Bowel infection	
Due to	
Other conditions	

0492
(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE F. F. Greenwell M. D. or other

Address Leonardtown Date signed Nov

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct answer is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 100

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. 415 8-51

1. PLACE OF DEATH:
COUNTY: CHARLES — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: LA PLATA
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Physic. MEMORIAL Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED:
POPES CREEK
STATE: MARYL. COUNTY: CHARLES.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Popes Creek
STREET ADDRESS (If rural, give location): ~~LA PLATA~~ MD.

3. NAME OF DECEASED: (Type or Print) (First) ANNA (Middle) ELIZABETH (Last) TURNER

4. DATE OF DEATH: (Month) NOV. (Day) 28th. (Year) 19 52

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
F	COLORED	MARRIED	SEPT. 15. 1900	52 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE.	Self —	CHARLES COUNTY	U.S.

13. FATHER'S NAME: MATHIAS MILBURN

14. MOTHER'S MAIDEN NAME: MARY THOMAS.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
NO		James Turner Husband

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

33IX

Immediate cause (a) RESPIRATORY COLLAPSE — Interval Between Onset and Death: 3 min.

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) CEREBRO-VASCULAR ACCIDENT — CA 24 Yrs

DUE TO

(c) HYPERTENSION — Years

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION:	20. AUTOPSY?
—	—	Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
—	—			

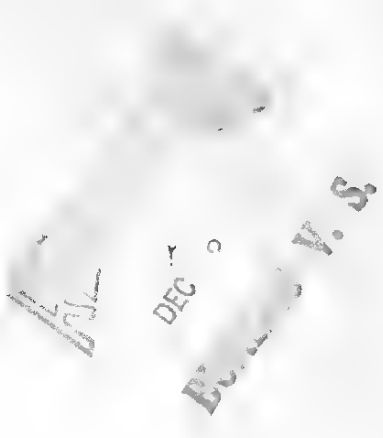
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
— M.	—	—

22. I hereby certify that I attended the deceased from 11: ..., 19 52, to 11: 28, 19 52 that I last saw the deceased alive on 11: 28, 19 52, and that death occurred at 730 P. m., from the causes and on the date stated above.

SIGNATURE: A Woody. MD (DEGREE OR TITLE) ADDRESS: La Plata. Md. DATE SIGNED: 28 Nov 52.

23. BURIAL, CREMATION REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
	Dec 2-52	Sacred Heart	La Plata	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
11/29/52	Julia H. Posey	Hamilton & Gyon	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U. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12481

Reg. Dist. No. 100

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 8-51

1. PLACE OF DEATH:
COUNTY: Charles — MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town): La Plata
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Physicians Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Md. COUNTY: Charles
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Waldorf
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED: (First) Mary (Middle) (Last) Vernon

4. DATE OF DEATH: (Month) (Day) (Year) November 2, 1952

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: Nov. 2, 1952

9. AGE last birthday: yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min. — 7

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): La Plata, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Ritchie Lee Vernon

14. MOTHER'S MAIDEN NAME: Mary Dorothy Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): no — (If Yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT & ADDRESS: Ritchie L. Vernon, Waldorf, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

776X

Immediate cause (a) Prematurity (26 weeks gestation) — INTERVAL BETWEEN ONSET AND DEATH: 7 hours.

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-2, 1952, to 11-2, 1952, that I last saw the deceased alive on 11-2, 1952, and that death occurred at 4:15 P.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS — DATE SIGNED

John N. Griffin, M.D. Hughesville, Md. 11/3/52

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: 11-3-52 — NAME OF CEMETERY OR CREMATORY: Piney Church — LOCATION (City, town, or county) (State): Waldorf, Md.

DATE REC'D BY LOCAL REG. 11-3-52 — REGISTRAR'S SIGNATURE: Julia H. Casey

24. FUNERAL DIRECTOR ADDRESS: Ritchie L. Vernon, Waldorf, Md. (father)

20X2374260

MARYLAND STATE DEPARTMENT OF HEALTH

12482

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 10-8

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Charles; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Welcome; MARYLAND; LENGTH OF STAY (In this Place) 1 2/12; HOSPITAL OR INSTITUTION OR STREET ADDRESS —

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md.; COUNTY Charles; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Welcome; STREET ADDRESS (If rural, give location) —

3. NAME OF DECEASED (Type or Print): (First) NELVIN (Middle) C (Last) WARREN

4. DATE OF DEATH: (Month) 11 (Day) 7 (Year) 1952

5. SEX: M

6. COLOR OR RACE: C

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): S

8. DATE OF BIRTH: 9-23-52

9. AGE last birthday: 0 yrs. If under 1 year: Months 1, Days 15, Hours —, If under 24 hrs: Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? —

13. FATHER'S NAME: VANCEY WARREN

14. MOTHER'S MAIDEN NAME: LILA BURROUGHS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): — (If yes, give war or dates of service): —

16. SOCIAL SECURITY No. —

17. INFORMANT AND ADDRESS: Vancey Warren, Welcome, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Broncho Pneumonia — Interval Between Onset and Death: 11-5-52

491X **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) —

(c) —

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION: — 19b. MAJOR FINDINGS OF OPERATION: — 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): — (CITY OR TOWN) — (COUNTY) — (STATE) —

TIME OF INJURY (Month) (Dey) (Year) (Hour) m.: — INJURY OCCURRED While at work ☐ Not while at work ☐ HOW DID INJURY OCCUR? —

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE C Hedelen (Degree or title) M.D. ADDRESS La Plata Md DATE SIGNED 11-8 52

23. BURIAL, CREMATION, REMOVAL, (Specify): Burial; DATE THEREOF 11/9/52; NAME OF CEMETERY OR CREMATORY Baptist; LOCATION (City, town, or county) (State) Hilltop, Md

DATE REC'D BY LOCAL REG. 11/9/52; REGISTRAR'S SIGNATURE Julia H. Rose

24. FUNERAL DIRECTOR ADDRESS Yancey Warren, Welcome, Md

VS. A15A

20922644 06

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NOV 12 1952
BUREAU V. S.

Item #9 - Film B 149.
12/4/52 mt

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 12483

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH:
COUNTY Charles — MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Spring Hill
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Charles
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Spring Hill
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) HENRY (Middle) F. (Last) Yates

4. DATE OF DEATH: (Month) Nov. (Day) 25 (Year) 19 52

5. SEX: M.

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): W.

8. DATE OF BIRTH: Apr. 23 1887

9. AGE last birthday: 65 ✓ yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U S

13. FATHER'S NAME: William Yates

14. MOTHER'S MAIDEN NAME: Emma ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No
(If Yes, give war or dates of service) —

16. SOCIAL SECURITY NO.: —

17. INFORMANT & ADDRESS: Margaret Savoy, Spring Hill, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

15 ✓
Immediate cause (a) CA Stomach — INTERVAL BETWEEN ONSET AND DEATH: 5 mo - 5 ✓

DUE TO

Antecedent cause(s)
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last
(b)
DUE TO
(c)

II. OTHER SIGNIFICANT CONDITIONS:
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) M.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-10, 19 52, to 11-25, 19 5✓, that I last saw the deceased alive on 11-23, 19 5✓, and that death occurred at ... m., from the causes and on the date stated above.
SIGNATURE E. C. Edelen (DEGREE OR TITLE) M.D. ADDRESS La Plata Md DATE SIGNED 11-26-5✓

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF 11/28/52
NAME OF CEMETERY OR CREMATORY St. Thomas
LOCATION (City, town, or county) (State) Bel Alton Md.

DATE REC'D BY LOCAL REG. 11/26/52
REGISTRAR'S SIGNATURE Julia H. Posey
24. FUNERAL DIRECTOR ADDRESS Hunt & Ryon, Waldorf, Md.

VS. A15 8-51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
DEC 1 1952
BUREAU V. S.